MARYLAND CONFIDENTIAL MORBIDITY REPORT (DHMH 1140)

(For use by physicians and other health care providers, but not laboratories. Laboratories should use forms DHMH 1281 & DHMH 4492.)

SEND TO YOUR LOCAL HEALTH DEPARTMENT

STATE DATA BASE NUMBER
(Completed by Health Department)

NAME OF PATIENT – LAST   FIRST   M

DATE OF BIRTH MONTH | DAY | YEAR

AGE

SEX M ☐ F ☐

ETHNICITY (Select independently of RACE)
HISPANIC or LATINO: YES ☐   NO ☐   UNKNOWN ☐

TELEPHONE NUMBERS
Home: Workplace:

RACE (Select one or more. If multiracial, select all that apply)
American Indian/Alaskan Native ☐   Asian ☐   Black/African American ☐
Hawaiian/Pacific Islander ☐   White ☐   Unknown ☐
Other (Specify):

ADDRESS   UNIT#   CITY OR TOWN   STATE   ZIP CODE   COUNTY

OCCUPATION OR CONTACT WITH VULNERABLE PERSONS
(Check all that apply - include volunteers)
☐ HEALTH CARE WORKER (Include any PATIENT CARE, ELDER CARE, "AIDES," etc.)
☐ DAYCARE (Attendee or Worker)
☐ PARENT of a child in DAYCARE
☐ FOOD SERVICE WORKER
☐ NOT EMPLOYED
☐ OTHER (SPECIFY):

WORKPLACE, SCHOOL, CHILD CARE FACILITY, ETC. (Include Name, Address, ZIP Code)

DISEASE OR CONDITION

PATIENT HAS BEEN NOTIFIED OF THIS CONDITION   YES ☐   NO ☐

DATE OF ONSET MONTH | DAY | YEAR

ADMITTED YES ☐   NO ☐

DATE ADMITTED MONTH | DAY | YEAR

HOSPITAL

CONDITION ACQUIRED IN MARYLAND
YES ☐   NO ☐   UNKNOWN ☐
(IF NO, INTERSTATE ☐, or INTERNATIONAL ☐)

SUSPECTED SOURCE OF INFECTION

DIED YES ☐   NO ☐

DATE DIED MONTH | DAY | YEAR

PREGNANT YES ☐   NO ☐   UNKNOWN ☐   NOT APPLICABLE ☐
WEEKS PREGNANT _____   DUE DATE _____

LABORATORY TESTS - VIRAL HEPATITIS

	POS	NEG	DATE
HAV Antibody Total	☐	☐	_____
HAV Antibody IgM	☐	☐	_____
HBV surface Antigen	☐	☐	_____
HBV e Antigen	☐	☐	_____
HBV core Antibody Total	☐	☐	_____
HBV core Antibody IgM	☐	☐	_____

LABORATORY TESTS - VIRAL HEPATITIS

	POS	NEG	DATE
HBV surface Antibody	☐	☐	_____
HBV Viral DNA	☐	☐	_____
HCV Antibody ELISA	☐	☐	_____
HCV ELISA Signal/Cut Off Ratio			_____
HCV Antibody RIBA	☐	☐	_____
HCV RNA (eg., by PCR)	☐	☐	_____

LABORATORY TESTS - VIRAL HEPATITIS

HCV Viral Genotyping _____ DATE _____
ALT (SGPT) Level _____ DATE _____
ALT – Lab Normal Range: _____ to _____
AST (SGOT) Level _____ DATE _____
AST – Lab Normal Range: _____ to _____
NAME of LAB: _____

ADDITIONAL LAB RESULTS
(SPECIMEN - TEST - RESULT - DATE - NAME of LAB)
(Please attach copies of lab reports whenever possible.)

PERTINENT CLINICAL INFORMATION + OTHER COMMENTS

HUMAN IMMUNODEFICIENCY VIRUS (HIV) and ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) – ADDITIONAL CASE INFORMATION

CONDITIONS	HIV LAB TESTS	DATE	RESULT
WEIGHT LOSS OR DIARRHEA ....☐	CD4+ T-cells < 200 per microliter or < 14%		
SECONDARY INFECTIONS (PCP, TB, etc.).........................☐	ELISA		
PERINATAL EXPOSURE OF NEWBORN ....☐	WESTERN BLOT		
OTHER CONDITIONS ATTRIBUTED TO HIV INFECTION ☐ (SPECIFY):	OTHER (SPECIFY):		

PHYSICIAN REQUESTS LOCAL HEALTH DEPARTMENT TO ASSIST WITH: NOTIFICATION TO PATIENT   YES ☐   NO ☐   PARTNER SERVICES   YES ☐   NO ☐

SEXUALLY TRANSMITTED INFECTION (STI) – ADDITIONAL CASE INFORMATION

SYPHILIS: PRIMARY ☐   SECONDARY ☐   EARLY LATENT (LESS THAN 1 YR) ☐   CONGENITAL ☐   OTHER STAGE ☐ (SPECIFY):

GONORRHEA: CERVICAL ☐   URETHRAL ☐   RECTAL ☐   PHARYNGEAL ☐   OPHTHALMIA NEONATORUM ☐   PID ☐   OTHER ☐ (SPECIFY):

CHLAMYDIA: CERVICAL ☐   URETHRAL ☐   RECTAL ☐   PHARYNGEAL ☐   PID ☐   OTHER ☐ (SPECIFY):

OTHER STI (Specify):

STI LABORATORY CONFIRMATION AND TREATMENT

Specify STI Lab Test (e.g., RPR Titer, FTA – TPPA, Darkfield, Smear, Culture, NAAT, EIA, VDRL - CSF)			STI Treatment Given ☐ (Specify date – drug – dosage below)		No Treatment Given ☐
DATE	TEST	RESULT	DATE	DRUG	DOSAGE

TUBERCULOSIS (Suspect or Confirmed) – ADDITIONAL CASE INFORMATION

MAJOR SITE: PULMONARY ☐   EXTRAPULMONARY ☐   ATYPICAL ☐ (SPECIFY)   **ABNORMAL CHEST X-RAY:** ☐

COMMENTS:

REPORTED BY
☐ Check here if completed by the Health Department

ADDRESS

TELEPHONE NUMBER

DATE OF REPORT MONTH | DAY | YEAR

NOTES: Your local health department may contact you following this initial report to request additional disease-specific information.
To print blank report forms or get more information about reporting, go to http://ideha.dhmh.maryland.gov/SitePages/what-to-report.aspx.

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